Exhibit A

STATE OF MICHIGAN THIRD JUDICIAL CIRCUIT WAYNE COUNTY	SUMMONS AND COMPLAINT	CASE NO. 16-015805-NF Hon. Megan Maher Brennan

2 Woodward Ave., Detroit MI 48226 Court Telephone No. 313-224-0121

Plaintiff		Defendant
MICHIGAN AMBULATORY SURGICAL CENTER, LLC, (re:	v	STATE FARM MUTUAL AUTOMOBILE INSURANCE COM
Plaintiff's Attorney Anthony Jered Bordoley, P-74864 30300 Northwestern Hwy Ste 321 Farmington Hills, MI 48334-3481		**Defendant's Attorney**

SUMMONS **NOTICE TO THE DEFENDANT:** In the name of the people of the State of Michigan you are notified:

1. You are being sued.
2. **YOU HAVE 21 DAYS** after receiving this summons to **file a written answer with the court** and serve a copy on the other party **or take other lawful action with the court** (28 days if you were served by mail or you were served outside this state). (MCR 2.111[C])
3. If you do not answer or take other action within the time allowed, judgment may be entered against you for the relief demanded in the complaint.

Issued	This summons expires	Court clerk
12/ 2/2016	3/ 3/2017	File & Serve Tyler

*This summons is invalid unless served on or before its expiration date. This document must be sealed by the seal of the court.

COMPLAINT ***Instruction: The following is information that is required to be in the caption of every complaint and is to be completed by the plaintiff. Actual allegations and the claim for relief must be stated on additional complaint pages and attached to this form.***

☐ This is a business case in which all or part of the action includes a business or commercial dispute under MCL 600.8035.

Family Division Cases

☐ There is no other pending or resolved action within the jurisdiction of the family division of the circuit court involving the family or family members of the parties.

☐ An action within the jurisdiction of the family division of the circuit court involving the family or family members of the parties has been previously filed in _____ Court.

The action ☐ remains ☐ is no longer pending. The docket number and the judge assigned to the action are:

Docket no.	Judge	Bar no.

General Civil Cases

☐ There is no other pending or resolved civil action arise out of the same transaction or occurrence as alleged in the complaint.

☐ An civil action between these parties or other parties arising out of the transaction or occurrence alleged in the complaint has been previously filed in _____ Court.

The action ☐ remains ☐ is no longer pending. The docket number and the judge assigned to the action are:

Docket no.	Judge	Bar no.

VENUE

Plaintiff(s) residence (include city, township, or village)	Defendant(s) residence (include city, township, or village)
Place where action arose or business conducted	

_____ _____

Date Signature of attorney/plaintiff

If you require special accommodations to use the court because of a disability or if you require a foreign language interpreter to help you fully participate in court proceedings, please contact the court immediately to make arrangements.

STATE OF MICHIGAN THIRD JUDICIAL CIRCUIT WAYNE COUNTY	**PROOF OF SERVICE**	CASE NO. 16-015805-NF

TO PROCESS SERVER: You are to serve the summons and complaint not later than 91 days from the date of filing or the date of expiration on the order for second summons. You must make and file your return with the court clerk. If you are unable to complete service you must return this original and all copies to the court clerk.

CERTIFICATE / AFFIDAVIT OF SERVICE / NONSERVICE

☐ **OFFICER CERTIFICATE** **OR** ☐ **AFFIDAVIT OF PROCESS SERVER**

I certify that I am a sheriff, deputy sheriff, bailiff, appointed court officer, or attorney for a party (MCR 2.104[A][2]), and that: (notarization not required)

Being first duly sworn, I state that I am a legally competent adult who is not a party or an officer of a corporate party, and that: (notarization required)

☐ I served personally a copy of the summons and complaint,

☐ I served by registered or certified mail (copy of return receipt attached) a copy of the summons and complaint, together with _____

List all documents served with the Summons and Complaint

_____

_____ on the defendant(s):

Defendant's name	Complete address(es) of service	Day, date, time

☐ I have personally attempted to serve the summons and complaint, together with any attachments, on the following defendant(s) and have been unable to complete service.

Defendant's name	Complete address(es) of service	Day, date, time

I declare that the statements above are true to the best of me information, knowledge and belief.

Service fee	Miles traveled	Mileage fee	Total fee
$	$	$	$

_____
Signature

_____
Name (type or print)

_____
Title

Subscribed and sworn to before me on _____ (Date), _____ County, Michigan.

My commission expires: _____ (Date) Signature: _____ (Deputy court clerk/Notary public)

Notary public, State of Michigan, County of _____

ACKNOWLEDGMENT OF SERVICE

I acknowledge that I have received service of the summons and complaint, together with _____ (Attachments)

_____ on _____ (Day, date, time)

_____ on behalf of _____

Signature

STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF WAYNE

MICHIGAN AMBULATORY SURGICAL CENTER, LLC,

Plaintiff, Hon.
Case No. -NF

-vs-

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY

Defendant.
_____/

16-015805-NF
FILED IN MY OFFICE
WAYNE COUNTY CLERK
12/2/2016 4:31:38 PM
CATHY M. GARRETT

Anthony J. Bordoley (P74864)
Attorney for Plaintiff
30300 Northwestern Hwy., Ste. 321
Farmington Hills, MI 48334
Phone - (248) 352-7680, Ext. 356
Fax - (248) 479-5900

_____/

A civil action between these parties or other parties arising out of the transaction or occurrence alleged in the complaint has been previously filed in UNITED STATES DISTRICT COURT EASTERN DISTRICT OF MICHIGAN SOUTHERN DIVISION. The action **remains** pending.
The docket number and the judge assigned to the action are:
Docket Number: 16-cv-10508, Honorable Paul D. Borman (P11015).

COMPLAINT

NOW COMES Plaintiff, Michigan Ambulatory Surgical Center, LLC, by and through its attorney, Anthony J. Bordoley, and for its Complaint states as follows:

1. That Plaintiff, Michigan Ambulatory Surgical Center, LLC, (hereinafter 'MASC') is a Michigan Corporation whose principal place of business is in the City of Oak Park, County of Oakland.

2. That Defendant, State Farm Mututal Automobile Insurance Comany, is an insurance company licensed to do business in the State of Michigan, and

conducting a regular, systematic and continuous part of its business in the Wayne County, Michigan.

3. That the amount in controversy herein does exceeds $25,000 and is otherwise within the jurisdiction of this Honorable Court.

4. That on or about August 9, 2014, injured person, Tamika Burrell, did sustain accidental bodily injuries in an accident arising out of the ownership, operation, maintenance, or use of a motor vehicle.

5. That Defendant is first in order of priority to pay for an injured person, Tamika Burrell's, claim for no fault personal protection insurance benefits in accordance with Chapter 31 of the Michigan Insurance Code, more commonly known as the "no fault insurance law".

6. That Defendant assigned claim number 224W13234 to the injured person, Tamika Burrell, claim.

7. That the above said automobile insurance policy contained the standard no-fault provisions pursuant to MCL 500.3101 et seq., a copy of which is in the possession of the Defendant.

8. That under the terms and conditions of Michigan No-Fault Automobile Insurance Act MCL 500.3101 et seq. (hereinafter referred to as 'No-Fault Act'), Defendant became obligated to pay to or on behalf of injured person, Tamika Burrell, certain expenses and losses if she sustained accidental bodily injuries in an accident arising out of the ownership, operation, maintenance, or use of a motor vehicle during the policy period.

9. That on numerous dates, the Plaintiff provided medical treatment to Defendant's insured, Tamika Burrell, for injuries he suffered as a result of her August 9, 2016 accident, there result of which are medical bills due and owing to Plaintiff.

10. That Plaintiff sought recovery from Defendant for the above stated personal protection benefits pursuant to the No-Fault Act.

11. That Plaintiff has fully complied with the requirements of the applicable contract of insurance and the No-Fault Act, and has provided Defendant with reasonable proof of all outstanding medical expense benefits owed at this time.

12. That Defendant has refused to pay Plaintiff necessary and incurred expenses at a reasonable and customary rate related to claimant, Tamika Burrell's, medical care in accordance with the contract provisions and the No-Fault Act.

13. That by wrongfully denying Plaintiff's claims, Defendant breached its statutory duty and is liable for that amount of coverage to which Plaintiff is rightfully entitled.

14. That the unpaid billings previously submitted for payment to the Defendant is $123,467.00, exclusive of interest, and costs. (**Exhibit A**).

15. That the Defendant’s refusal of Plaintiff’s billings is unreasonable.

16. That all applicable set-offs have been applied.

17. That the Defendant is liable for Plaintiff’s attorney fees pursuant to MCL 500.3148 for its unreasonable refusal of Plaintiff’s billing.

WHEREFORE, Plaintiff, Michigan Ambulatory Surgical Center, LLC, prays for a Judgment against Defendant in an amount to exceed $25,000.00 together with all past and presently owed no-fault benefits, interest, costs, no-fault penalty interest and no-fault penalty attorney fees.

Respectfully Submitted,
Martin W. Bordoley, P.C.

By: /s/Anthony J. Bordoley

Anthony J. Bordoley (P74864)
Attorney for Plaintiff
30300 Northwestern Hwy. Suite 321
Farmington Hill's, MI 48834
(248) 352-7680, Ext. 356

EXHIBIT A

PO BOX 661023

DALLAS TX 75266-75266

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Page 1 of 2

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#) X	1a. INSURED'S I.D. NUMBER (For Program in Item 1) 224W13234
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) BURRELL TAMIKA	3. PATIENT'S BIRTH DATE MM DD YY 04 28 75 SEX M F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial) BURRELL TAMIKA	
5. PATIENT'S ADDRESS (No., Street) 16842 AVON AVENUE	6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street) 16842 AVON AVENUE	
CITY DETROIT STATE MI	8. RESERVED FOR NUCC USE
CITY DETROIT STATE MI	
ZIP CODE 48219 TELEPHONE (Include Area Code) ( )	
ZIP CODE 48219 TELEPHONE (Include Area Code) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO
a. INSURED'S DATE OF BIRTH MM DD YY 04 28 75 SEX M F X	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES X NO
c. INSURANCE PLAN NAME OR PROGRAM NAME STATE FARM AUTO	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a, and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 02 09 2016

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN Zamorano Lucia M.D.	17a. 17b. NPI 1770549010
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. M542 B. M5002 C. D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	02 09 16	02 09 16	24		63075	50	AB	30661 00	1		NPI	1770549010
2	02 09 16	02 09 16	24		22554	50 59	AB	32947 00	1		NPI	1770549010
3	02 09 16	02 09 16	24		22845	50	AB	6288 00	1		NPI	1770549010
4	02 09 16	02 09 16	24		22851	50	AB	3497 00	1		NPI	1770549010
5	02 09 16	02 09 16	24		22585	50 59	AB	3012 00	1		NPI	1770549010
6	02 09 16	02 09 16	24		63076	50 59	AB	39287 00	1		NPI	1770549010

25. FEDERAL TAX I.D. NUMBER SSN EIN 611723805 X	26. PATIENT'S ACCOUNT NO. 0000189	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED L Zamorano M.D. DATE 02/09/16	32. SERVICE FACILITY LOCATION INFORMATION Michigan Amb Surgical Center 22000 Greenfield Rd OAK PARK, MI 48237 a. 1790109445 b.		33. BILLING PROVIDER INFO & PH # (248) 206-2990 Michigan Amb Surgical Center 22000 Greenfield Rd OAK PARK, MI 48237 a. 1790109445 b.	

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

PO BOX 661023

DALLAS TX 75266-75266

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Page 2 of 2

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#) X

1a. INSURED'S I.D. NUMBER: 224W13234

2. PATIENT'S NAME: BURRELL TAMIKA

3. PATIENT'S BIRTH DATE: 04 28 75 SEX: M F X

4. INSURED'S NAME: BURRELL TAMIKA

5. PATIENT'S ADDRESS: 16842 AVON AVENUE

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS: 16842 AVON AVENUE

CITY: DETROIT STATE: MI

8. RESERVED FOR NUCC USE

CITY: DETROIT STATE: MI

ZIP CODE: 48219 TELEPHONE: ( )

ZIP CODE: 48219 TELEPHONE: ( )

9. OTHER INSURED'S NAME

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO X

a. INSURED'S DATE OF BIRTH: 04 28 75 SEX: M F X

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO X PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATE FARM AUTO

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 02 09 2016

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Zamorano Lucia M.D.

17a.

17b. NPI 1770549010

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. M542 B. M5002 C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 02 09 16	02 09 16	24		77003	59	AB	241 00	1		NPI	1770549010
2 02 09 16	02 09 16	24		20930	50	AB	734 00	1		NPI	1770549010
3 02 09 16	02 09 16	24		L8699	50	AB	1700 00	1		NPI	1770549010
4 02 09 16	02 09 16	24		L8699	50	BA	1700 00	1		NPI	1770549010
5 02 09 16	02 09 16	24		L8699	50	AB	3400 00	1		NPI	1770549010
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 611723805 SSN EIN X

26. PATIENT'S ACCOUNT NO.: 0000189

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE: $ 123467 00

29. AMOUNT PAID: $ 0 00

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED: L Zamorano M.D. DATE: 02/09/16

32. SERVICE FACILITY LOCATION INFORMATION

Michigan Amb Surgical Center
22000 Greenfield Rd
OAK PARK, MI 48237

a. 1790109445 b.

33. BILLING PROVIDER INFO & PH #: (248) 206-2990

Michigan Amb Surgical Center
22000 Greenfield Rd
OAK PARK, MI 48237

a. 1790109445 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)